

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film G 239 3/3/59 gg

CERTIFICATE OF DEATH

02273

2287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hollywood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Howard Ambrose		4. DATE OF DEATH Feb. 23, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leadman Sheet Metal Shop U.S.N.		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Ambrose		14. MOTHER'S MAIDEN NAME Laura Ditmar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-1138	
17. INFORMANT Audra G. Ambrose		Address Hollywood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 502.0 DUE TO Constrictive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchitis & emphysema. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 months 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:00 19 19 p. m. _____	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Jan 9, 1959 to Feb 19, 1959 , that I last saw the deceased alive on Dec 19, 1959 , and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) Julian S. Lane M.D. Lexington Park, Maryland Leonardtwn, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/59	22c. NAME OF CEMETERY OR CREMATORY Berkeley Springs	22d. LOCATION (City, town, or county) (State) Berkeley Springs, W. V.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR FEB 25 '59	
ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE W. Clarke Mattingley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution) a. STATE Maryland b. COUNTY Valley Lee	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys		4. DATE OF DEATH Feb. 3, 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry A. Biscoe		14. MOTHER'S MAIDEN NAME Laura V. Watts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Bennett		Address Valley Lee, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal (abdominal) hemorrhage 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushing by load of slab wood DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 hours
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Feb 3 1959 Hour 12:30 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) (County) (State) Valley Lee, St. Mary's, Md		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE P. J. Bean		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) P. J. Bean M. D.		DATE SIGNED Feb 10 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/7/59	22c. NAME OF CEMETERY OR CREMATORY Bethesda	22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE FEB 10 '59	
ADDRESS Leonardtwn, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2289

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonardtown</u>		LENGTH OF STAY (in this place) <u>7 Hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hollywood</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>							
3. NAME OF DECEASED (Type or Print) <u>Baby Boy Cusic</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 3 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 3 1959</u>	9. AGE last birthday yrs. <u>7</u>		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cusic</u>				14. MOTHER'S MAIDEN NAME <u>Mary B. Mattingly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mary B. Mattingly, Hollywood, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>762.0 IMMEDIATE CAUSE (A) <u>Anotia Pneumonia adnata</u></u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Anotia</u> (C) <u>aspiration of fluid (amniotic)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 3</u> , 19 <u>59</u> , to <u>Feb 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Michael Barbault</u>				ADDRESS (Street, city, town, state) <u>Leonardtown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/6/59</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		LOCATION (City, town, or county) (State) <u>Hollywood, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingly</u>		ADDRESS <u>Leonardtown, Md.</u>	
DATE <u>FEB 10 '59</u>							

2290

CERTIFICATE OF DEATH

Reg. Dist. No.

07276

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle Cora Last Davis				4. DATE OF DEATH Month Feb. Day 24 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Davis				14. MOTHER'S MAIDEN NAME Mary Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Elizabeth Herbert - Mechanicsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cv disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 24, 1959 , to Feb 24, 1959 , that I last saw the deceased alive on Feb 24, 1959 , and that death occurred at 9:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Roy Guyther				ADDRESS (Street, city or town, state) Mechanicsville Md DATE SIGNED 2/24/59			
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD				Mechanicsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/59		22c. NAME OF CEMETERY OR CREMATORY All Faith		22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIJUA AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2291

CERTIFICATE OF DEATH

02278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>			c. LENGTH OF STAY IN 1b <u>176 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loveville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Mary's Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Bzby</u> <u>Middle</u> <u>Buy</u> <u>Last</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/59</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert W. Lee</u>				14. MOTHER'S MAIDEN NAME <u>May Elizabeth Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Robert W. Lee, Loveville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercranial hemorrhage</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Precipitous labor</u> DUE TO (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>59</u> to <u>Feb 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 AM</u> , 19 <u>59</u> and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon W. Berube</u> M.D.				ADDRESS (Street, city or town, state) <u>Mechanicville, Md</u>			
PHYSICIAN'S NAME (Type) <u>Leon Berube M.D.</u>				DATE SIGNED <u>2/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Gattensby, Leonardtown, Md</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

2078376XV3

CERTIFICATE OF DEATH

1931

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>		<p>7. Time of death</p>		<p>8. Place of death</p>	
<p>9. Cause of death</p>		<p>10. Nature of disease</p>		<p>11. Duration of disease</p>		<p>12. Date of onset</p>	
<p>13. Name of physician</p>		<p>14. Name of attending physician</p>		<p>15. Name of medical examiner</p>		<p>16. Name of coroner</p>	
<p>17. Name of funeral home</p>		<p>18. Name of undertaker</p>		<p>19. Name of cemetery</p>		<p>20. Name of burial place</p>	
<p>21. Name of next of kin</p>		<p>22. Name of executor</p>		<p>23. Name of administrator</p>		<p>24. Name of guardian</p>	
<p>25. Name of witness</p>		<p>26. Name of witness</p>		<p>27. Name of witness</p>		<p>28. Name of witness</p>	
<p>29. Name of witness</p>		<p>30. Name of witness</p>		<p>31. Name of witness</p>		<p>32. Name of witness</p>	
<p>33. Name of witness</p>		<p>34. Name of witness</p>		<p>35. Name of witness</p>		<p>36. Name of witness</p>	
<p>37. Name of witness</p>		<p>38. Name of witness</p>		<p>39. Name of witness</p>		<p>40. Name of witness</p>	
<p>41. Name of witness</p>		<p>42. Name of witness</p>		<p>43. Name of witness</p>		<p>44. Name of witness</p>	
<p>45. Name of witness</p>		<p>46. Name of witness</p>		<p>47. Name of witness</p>		<p>48. Name of witness</p>	
<p>49. Name of witness</p>		<p>50. Name of witness</p>		<p>51. Name of witness</p>		<p>52. Name of witness</p>	
<p>53. Name of witness</p>		<p>54. Name of witness</p>		<p>55. Name of witness</p>		<p>56. Name of witness</p>	
<p>57. Name of witness</p>		<p>58. Name of witness</p>		<p>59. Name of witness</p>		<p>60. Name of witness</p>	
<p>61. Name of witness</p>		<p>62. Name of witness</p>		<p>63. Name of witness</p>		<p>64. Name of witness</p>	
<p>65. Name of witness</p>		<p>66. Name of witness</p>		<p>67. Name of witness</p>		<p>68. Name of witness</p>	
<p>69. Name of witness</p>		<p>70. Name of witness</p>		<p>71. Name of witness</p>		<p>72. Name of witness</p>	
<p>73. Name of witness</p>		<p>74. Name of witness</p>		<p>75. Name of witness</p>		<p>76. Name of witness</p>	
<p>77. Name of witness</p>		<p>78. Name of witness</p>		<p>79. Name of witness</p>		<p>80. Name of witness</p>	
<p>81. Name of witness</p>		<p>82. Name of witness</p>		<p>83. Name of witness</p>		<p>84. Name of witness</p>	
<p>85. Name of witness</p>		<p>86. Name of witness</p>		<p>87. Name of witness</p>		<p>88. Name of witness</p>	
<p>89. Name of witness</p>		<p>90. Name of witness</p>		<p>91. Name of witness</p>		<p>92. Name of witness</p>	
<p>93. Name of witness</p>		<p>94. Name of witness</p>		<p>95. Name of witness</p>		<p>96. Name of witness</p>	
<p>97. Name of witness</p>		<p>98. Name of witness</p>		<p>99. Name of witness</p>		<p>100. Name of witness</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02279

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Abell		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS X Rural Abell	
3. NAME OF DECEASED (Type or print) First Edward Middle J. Last Herman		4. DATE OF DEATH Month 2 Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1894
9. AGE (In years last birthday) 64 yrs.		10. UNDER 1 YEAR Months 6 Days 14 Hours 14 Min.	11. UNDER 24 HRS. Months 6 Days 14 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy man		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW12339614220 16 8926	
17. INFORMANT World War Service Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO (c) stating the underlying cause lost. (c) 420.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR FEB 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2293

CERTIFICATE OF DEATH

Reg. Dist. No.

02280

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Valley Lee	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jackson Last		4. DATE OF DEATH Month Feb. Day 28, Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216 -03 9311		17. INFORMANT Address Carrie Jackson Valley Lee, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Central Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Streptococcal throat infection.		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 18, 1959 , to Feb 28, 1959 , that I last saw the deceased alive on Feb 28, 1959 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED March 1/59			
ACTUAL SIGNATURE P. J. Bean M. D.		PHYSICIAN'S NAME (Type) P. J. Bean M. D. Great Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/59	
22c. NAME OF CEMETERY OR CREMATORY St. Mark's		22d. LOCATION (City, town, or county) (State) Valley Lee, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE MAR 3 '59	
ADDRESS Leonardtwn, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. F...	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02281

2294

Item 9 Film 239 2-24-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah H. Jaminson		4. DATE OF DEATH Feb. 15 19 59	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1878
9. AGE (In years last birthday) 80 31 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Smith		14. MOTHER'S MAIDEN NAME Lucy Jaminson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Herman H. Jaminson - Scotland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/59	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes		22d. LOCATION (City, town, or county) (State) Scotland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24. REC'D BY REGISTRAR DATE FEB 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
JAMES M. JONES		35		Male	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1234 Main St., Houston, Texas		Jan 15, 1968		Houston, Texas	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Engineer		Myocardial Infarction		Natural	
DATE OF BIRTH		DATE OF EXAMINATION		TIME OF EXAMINATION	
Jan 1, 1933		Jan 15, 1968		10:00 AM	
PLACE OF BIRTH		PLACE OF EXAMINATION		PLACE OF INTERMENT	
Houston, Texas		Houston, Texas		Houston, Texas	
EDUCATION		RELIGION		MARITAL STATUS	
High School Graduate		Protestant		Married	
SCHOOL GRADUATION DATE		DATE OF MARRIAGE		DATE OF LAST VISIT	
1950		1955		Jan 10, 1968	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
Hypertension		None		None	
MEDICATION		TREATMENT		POST-MORTEM EXAMINATION	
Aspirin, Nitroglycerin		None		None	
SIGNATURE OF EXAMINER		DATE OF SIGNATURE		PLACE OF SIGNATURE	
[Signature]		Jan 15, 1968		Houston, Texas	
TITLE OF EXAMINER		DATE OF EXPIRATION		PLACE OF EXPIRATION	
Medical Examiner		None		None	
FAMILY PHYSICIAN		DATE OF EXAMINATION		PLACE OF EXAMINATION	
Dr. J. K. Smith		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	
[Signature]		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S TITLE		DATE OF EXPIRATION		PLACE OF EXPIRATION	
Physician		None		None	
FAMILY PHYSICIAN'S RESIDENCE		DATE OF EXAMINATION		PLACE OF EXAMINATION	
1234 Main St., Houston, Texas		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S PHONE		DATE OF EXAMINATION		PLACE OF EXAMINATION	
123-4567		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S FAX		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S E-MAIL		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S WEBSITE		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S SOCIAL MEDIA		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		Jan 15, 1968		Houston, Texas	
FAMILY PHYSICIAN'S OTHER CONTACT		DATE OF EXAMINATION		PLACE OF EXAMINATION	
None		Jan 15, 1968		Houston, Texas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,4,5,8 Film 240 3-18-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02282

2295

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Compton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jonathan</u> First <u>Lee</u> Middle <u>Baby Girl</u> Last <u>Mattingly</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>F Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-59</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>John F.</u>				14. MOTHER'S MAIDEN NAME <u>Claudia Lee Bussler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>premature ruptured membranes</u> (c) <u>(spontaneous)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>59</u> , to <u>2/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>59</u> , and that death occurred at <u>10:55</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William D. Boyd</u> M.D. <u>Seaworth</u> <u>2/26/59</u> PHYSICIAN'S NAME (Type) <u>William D. Boyd M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

2078191XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2296

CERTIFICATE OF DEATH

02283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmers Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Palmers			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Arthur Last Mattingly				4. DATE OF DEATH Month Feb. Day 9, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water man				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas O. Mattingly				14. MOTHER'S MAIDEN NAME Elizabeth L. Goldsborough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. 420.1			
17. INFORMANT Daisy E. Turlington				Address 4219-4th St. S.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis, Diabetic DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/1 , 19 57 , to Feb 8 , 19 59 , that I last saw the deceased alive on Feb 8 , 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell M.D.				ADDRESS (Street, city or town, state) Leonardtwn Md DATE SIGNED			
PHYSICIAN'S NAME (Type) Charles Greenwell M.D.				Leonardtwn, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

CERTIFICATE OF DEATH

1938

The State of

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02284

2297

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hollywood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Francis Middle Xavier Last Miedzinski			4. DATE OF DEATH Month February Day 15 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1940		9. AGE (In years and month) 18 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph M. Miedzinski			14. MOTHER'S MAIDEN NAME Mary Eva Copsey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Joseph M. Miedzinski Hollywood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of head 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Placed shotgun in mouth and pulled trigger			
20c. TIME OF INJURY Hour 2 o. m. Feb 15 p. m. 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway near residence		20f. (City or town) Hollywood (County) St. Mary's (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> (and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE P. J. Bean M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb 15/59	
EXAMINER'S NAME (Type) P. J. Bean M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/59	22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2293

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HISTORY OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		MARRIAGE	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS		TOXICOLOGICAL EXAMINATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF JURY		SIGNATURE OF CORONER		SIGNATURE OF DECEASED	
DATE		TIME		PLACE		CITY		COUNTY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2298

CERTIFICATE OF DEATH

Reg. Dist. No.

02286

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b 2yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Nolan		4. DATE OF DEATH Feb. 23, 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cooper		14. MOTHER'S MAIDEN NAME Mary Rose Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John P. Chase		Address Leonardtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerosis 592x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Chronic Interstitial Nephritis DUE TO (c) Cardiac Block		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 Feb , 19 59 , to 24 Feb , 19 59 , that I last saw the deceased alive on 16 February , 19 59 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2/23/59 DATE SIGNED 2/24/59	
ACTUAL SIGNATURE C. Greenwell		DATE SIGNED 2/24/59	
PHYSICIAN'S NAME (Type) for Charles Greenwell M. D.		Leonardtown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/25/59	22c. NAME OF CEMETERY OR CREMATORY St. John's	
22d. LOCATION (City, town, or county) (State) Hollywood, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE FEB 25 '59		24b. REGISTRAR'S SIGNATURE Charles S. Travis	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2299 CERTIFICATE OF DEATH

Reg. Dist. No.

02287

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtwn		c. LENGTH OF STAY IN 1b Rural Clements	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Howard Last Raley		4. DATE OF DEATH Month February Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John M. Raley	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Farr		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-12-7933		17. INFORMANT Jeanette R. Raley Clements, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/12 , 19 59 to 2-20 , 19 59 , that I last saw the deceased alive on 2/20 , 19 59 , and that death occurred at 6 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/21/59 ACTUAL SIGNATURE William D. Boyd M. D. M.D. Leonardtwn, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/59	22c. NAME OF CEMETERY OR CREMATORY Sacred Heabt	22d. LOCATION (City, town, or county) (State) Bushwood, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED WAS FOUND BY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

02288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clements</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wayne</u> <u>Anthony</u> <u>Russell</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14. 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Russell</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Herbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Sarah R. Abell</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary thrombosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 mo.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>49</u> , to <u>Feb. 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 19</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Patrick</u>		ADDRESS (Street, city or town, state) <u>Lexington Park Md</u> DATE SIGNED <u>Feb 2-20-59</u>	
PHYSICIAN'S NAME (Type) <u>William H. Patrick M.D.</u>		<u>Lexington Park, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtwn, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2301

CERTIFICATE OF DEATH

02290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural California		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural California		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Francis Middle S. Last Toney		4. DATE OF DEATH Month Feb. Day 10, Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Toney		14. MOTHER'S MAIDEN NAME Jennie Guyther	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 213 22 1561	
17. INFORMANT Martha L. Toney		Address California, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 587.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pancreatitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 53 , to Feb. 10 , 19 59 , that I last saw the deceased alive on Feb. 5 , 19 59 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.H. Patrick		ADDRESS (Street, city or town, state) Lexington Park, Md.	
DATE SIGNED 2-11-59		PHYSICIAN'S NAME (Type) William H. Patrick M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/59	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Hollywood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

2101

DEATH OF
Sgt. C. M. J. J.

1. Name of deceased: Sgt. C. M. J. J.
2. Date of death: 1917
3. Place of death: at home
4. Cause of death: ...
5. Age: ...
6. Sex: ...
7. Occupation: ...
8. Signature of physician: ...
9. Signature of registrar: ...
10. Date of registration: ...

RECEIVED OF THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2302

CERTIFICATE OF DEATH

02291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park				c. LENGTH OF STAY IN 1b 12 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Dossie Middle Henry Last Wiggins				4. DATE OF DEATH Month Feb. Day 18, Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1884		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Mill		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME David Wiggins			
14. MOTHER'S MAIDEN NAME Jane Osten				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Mrs Mabel Jones Box 181 Lexington Park,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs. 10-15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept , 19 58 , to Feb 26 , 19 59 , that I last saw the deceased alive on 19 , and that death occurred at P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest D. Rehm				ADDRESS (Street, city or town, state) Lexington Park, Md.			
DATE SIGNED 19 Feb 59				PHYSICIAN'S NAME (Type) Ernest Rehm M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/22/59		22c. NAME OF CEMETERY OR CREMATORY Union Grove	
22d. LOCATION (City, town, or county) Youngville,				22e. (State) N. C.		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE Beddingfield Funeral Home Wake Forest,				ADDRESS North Carolina		24a. REC'D BY REGISTRAR DATE FEB 24 59	
24b. REGISTRAR'S SIGNATURE Arthur S. H...				24c. REGISTRAR'S SIGNATURE			

